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No Relevant Association Between Coronary Artery Ectasia and Mean Platelet Volume, Gamma Glutamyl Transferase and Uric Acid Levels

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Objectıves: In this study we aimed to investigate whether there is an association between mean platelet volume (MPV), gamma glutamyl transferase (GGT), uric acid and coronary artery ectasia (CAE) in a large patient population.
Methods: A total of 406 patients (245 male, mean age 55±9 years) were selected as study population in a retrospective manner from 3265 individuals who have undergone coronary angiography between August 2011 and December 2012. Study population was consisting of four groups including 117 (%29) patients with isolated CAE, 109 (%27) patients with both CAE and severe stenosis in at least one coronary artery, 104 (%26) patients with isolated significant coronary stenosis and 76 (%18)patients with normal coronary arteries (NCA) as control group. Detailed evaluation of all coronary angiograms was performed by two experienced interventional cardiologist. Information regarding blood tests of patients obtained during hospitalisation were extracted from Institute electronic database.
Results: MPV, GGT, and uric acid levels were significantly higher in subjects with stenotic coronary artery disease (CAD) and in subjects with both CAD and CAE compared with subjects with isolated CAE and subjects with NCA. There were no significant differences between subjects with isolated CAE and NCA groups in terms of MPV (8.6±1.2 fL to 8.6±1.1, p=0.993), serum GGT (33±15 U/L to 30±15 U/L, p=0.723) and uric acid levels (5.4±1.6 mg/dl to 5.2±1.7 mg/dl, p=0.845).
Conclusıon: Unlike with previous studies our study failed to demonstrate any association between CAE and MPV, uric acid and GGT levels.

Table: Laboratory parameters and clinical characteristics of patients and controls

	CAE Group n=117	CAD + CAE Group, n=109	CAD Group n=104	NCA Group n=76	P value
Age (Years)	54.4 ± 9	55.2 ± 9	56.5 ± 10	55.5 ± 9	0.34
Gender (Male/Female)	70/47	69/40	66/38	40/36	0.43
BMI (kg/m²)	29.6±4	30.1±4	30.6±5	30.5±4	0.34
Diabetes n, (%)	27 (23)	25 (23)	23 (22)	18 (23)	0.98
Hypertension n, (%)	37 (31)	37 (34)	36 (34)	24 (31)	0.61
Smoking n, (%)	55 (47)	51 (46)	49 (47)	36 (47)	0.95
Fasting glucose (mg/dl)	90 ± 13	90 ± 15	89 ± 10	90 ± 11	0.95
Creatinine (mg/dl)	1.07 ± 0.2	1.01 ± 0.2	1.03 ± 0.2	1.04 ± 0.1	0.14
LDL Cholesterol (mg/dl)	122 ± 33	125 ± 39	132 ± 41	119 ± 32	0.07
Triglyceride (mg/dl)	156 ± 67	162 ± 69	171 ± 53	161 ± 70	0.40
Hemoglobin (mg/dl)	13.7 ± 3	13.8 ± 3	13.9 ± 3	14 ± 2	0.92
WBC count (x 10³/L)	7.2 ± 1.1*	7.8 ± 1.2	7.5 ± 1.4	6.7 ± 1.5	<0.001
MPV (fL)	8.6 ± 1.2*	9.3 ± 1.3	9.2 ± 1.2	8.6 ± 1.1	<0.001
GGT (U/L)	33 ± 15 *	45 ± 17	46 ± 17	30 ± 13	<0.001
Uric Acid (mg/dl)	5.4 ± 1.6*	6.6 ± 1.8	6.4 ± 1.5	5.2 ± 1.7	<0.001
Ejection fraction (%)	57 ± 9	58 ± 9	59 ± 6	59 ± 8	0.56

* p< 0.05 in post-hoc analyses when isolated CAE group is compared with CAD group and CAD+CAE group

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Low Efficiency of the Standard Dosing of Unfractionated Heparin in Patients NSTEMI Elderly Female and Moderate Chronic Kidney Disease Hospitalized Within 12 Hours

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Purpose: To study the effectiveness of a standard dose of unfractionated heparin in patients nSTEMI in a subgroup of elderly women and moderate chronic kidney disease at a delay of more than 12 hours of hospitalization.

Studied 306 patients nSTEMI, hospitalized within 12 hours, which were divided into 4 sub-group: patients ≥65 years (n=98) and women (n=79), patients with CKD stage 3 (n=84) and control group (under 65 years, men without CKD 3). All patients received infusion of unfractionated heparin recommended in the Guidelines scheme bolus is 4,000 units, followed by infusion of not more 1000U \ hour. Every 6 hours for 48 hours, the measured level of APTT. The target level was 2×normal range of aPTT
Results: In the indicated dosages in the elderly for the first 18 hours you can not achieve the required numbers aPTT. In women, the first two indicators (12:00 heparin therapy) was significantly lower than control values (43,4±1,27 s., p=0.04 and from 42,1±2,02, p=0.009). Further indicators aPTT significantly improving and benchmarking. Subgroup renal disease is more difficult with the correct amount of APTT (APTT 1 - 41,0±2,53 s., p=0.03, aPTT 2 - 40,1±2,31 s., p=0.004, aPTT 3 - 44,8±2.14 s., p=0.02, aPTT 4 -51,4±1,11 s, p=0.03, aPTT 5 - 49,3±2,31 s, p=0.02. 6 and 7 shows the measurement data comparable to the control, but the eight measurement was again significantly less than control values. Results of the analysis indicate only about 50% of the patients included in the study, reach a therapeutic aPTT level in international schemes recommended dosage.
Conclusıons: The proposed internationally recommended dose of UFH in patients with reduced GFR and the elderly, can not provide the required values of APTT in the early hours and did not reach the level of anticoagulation observed in the control group. With late hospitalization in these sub-groups must use higher doses of heparin, especially in the first 12 hours.

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The Coronary Care Unit Profile and Outcomes: What Has Changed in the Last Decade?

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Aım: Coronary care unıts (CCU) are specialised centers for performing monitorization, follow-up and treatment of coronary, noncoronary cardiac and other noncardiac emergencies. We aim to show the features of patients recieving care of coronary unit and to determine the changes of approach at a tertiary cardiac center in the same time period more than 10 years apart.
Materıal-Methods: We included all consecutive patients hospitalized in the CCU between 1998 to 2013. We constitute 2 groups. Group 1 (between 1998 to 2002) had 2041, Group 2 (between 2011 to 2013) had 1181 patients. We compared diagnostic distributions, features of cases and in-hospital mortality rates between two groups.
Results: The mean age and female gender distribution was 59±10 years, 24% in group 1, 63±12 years and 28% in group 2. Group 1 consists of 79% acute coronary syndromes (ACS) (59% ST elevated (STEMI), 41% nonST elevated); 9% ryhthm and conduction disturbances; 7% left ventricular heart failure and pulmonary edema; 1.9% cardiogenic shock and cardiopulmonary arrest; 3% others (Valvular heart diseases, aortic dissection, digital intoxication, pericardial effusion and tamponate, syncope, chronic obstructive pulmonary diseases etc.). Group 2 consists of 72% ACS (40% STEMI, 60% non ST elevated); 13% ryhthm and conduction disturbances; 9% left ventricular heart failure and pulmonary edema; 1.3% cardiogenic shock and cardiopulmonary arrest; 4,7% others (Valvular diseases, aortic dissection, digital intoxication, pericardial effusion and tamponate, syncope, chronic obstructive pulmonary diseases etc.) (Table 1).

Overall in-hospital mortality of groups was 9.0% and 4.4% respectively. (Table1) According to their diagnosis ıt was 6% for ACS (6% for STEMI; 5% for Non ST elevated) in group 1; 4.3% for ACS (5% for STEMI; 4.1% for Non ST elevated) in group 2. The revascularization strategy of two groups was different. Thrombolysis was 92% in group 1, whereas primary percutaneous coronary intervention was 98% in group 2. CCU length of stay was 6 ±4 day and 100 ± 15 hours in group 1, 4±3 day and 39±13 hours in group 2 for all patients and cases with ACS respectively.
Conclusıon: ACS continue to be vast majority of cases in CCU. New pharmacologic and interventional strategies provide the notable reduction in mortality from ACS. It is noticed that there is a reduction in STEMI cases and increase in non ST elevation ACS and also age of ACS cases.